MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
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Washington, D.C.

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COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
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AUTRY O.V. "PETE" DeBUSK
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JOSEPH P. NEWHOUSE, Ph.D.
JANET G. NEWPORT
CAROL RAPHAEL
ALICE ROSENBLATT
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

AGENDA ITEM: Issues affecting the Medicare benefit package
-- Mae Thamer, Helaine Fingold, Chantal Worzala, David Glass
.. Beneficiaries and medical practice
.. Supplemental insurance

DR. THAMER: As you've just heard, although Medicare has been largely successful in meeting its goals of financial protection and access to care for many beneficiaries, it's important to consider whether there are trends in the composition of the Medicare population and in the scope and delivery of medical care that might make its future success less certain. In this presentation we will briefly review the contents of this chapter, Issues Facing the Medicare Benefit Package, and we hope to get commissioners' guidance and recommendations on possible revisions.

This chapter discusses four major demographic trends that you've seen before. The first one, the older population in the U.S. is growing rapidly as reflected by the fact that currently Medicare serves 40 million, which is approximately twice the number it did at the program's inception, and it's going to double again by 2030 to exceed 70 million persons.

The second trend is that the fastest growing segment of the older population is the 85-plus group which now numbers 4.2 million and is expected to reach nearly 9 million in 2030.

The third important trend is that the under-65 disabled population is increasing at a growth rate that's significantly faster than that of the elderly population. Since Medicare began providing health care services to disabled individuals in 1973 enrollment has grown from 1.7 million to more than 5.2 million persons.

Finally, the last trend that we think is very important is that disability from chronic conditions among the elderly has declined substantially over the last two decades. This trend has led many experts to conclude that there may be a compression of morbidity and mortality into the last few months or year of life.

These demographic trends have particular significance for Medicare beneficiaries and what they need since the importance of various benefits changes based on one's health status. One useful way to think about the beneficiary population is to divide it into three segments according to health status as follows. The first group is basically healthy except for acute episodes. This group in particular may require preventive services and access to routine care.

A second group are people with serious chronic conditions who are at risk for further deterioration and who represent significant current and future cost to the program. This group needs ongoing coordinated care from multiple providers and often from multiple institutions, and they require protection from potential catastrophic costs.

The last group, the third group are people who are terminally ill and nearing the end of life. Hospice and

palliative care are of particular importance to this group.

The importance of the perceived gaps in the Medicare benefit package that are listed in this slide, they can differ by what group a beneficiary is in. For example, while the lack of a prescription drug benefit affects the entire Medicare population, it may be of particular importance for those with chronic conditions or those at the end of life who require pain management.

Similarly, use of preventive services may be most relevant to the generally healthy aged although it has a potential to prevent further deterioration among those with chronic conditions as well.

Finally, advances in mental health services most directly affect those who have severe mental conditions, but since mental conditions, particularly affective disorders, are a common comorbid condition for people who have chronic conditions, improvements in mental health services could also affect this group.

For the remainder of this presentation we would really just like to hear from the commissioners regarding whether this chapter presents an adequate and comprehensive background as well as provides compelling reasons for the options that are later delineated in Chapter 3. Specifically, issues of tone, missing topics, topics that are overlooked, or topics that may not have been adequately covered we'd be interested in hearing about.

MR. HACKBARTH: If we're focusing on the fact that the population served is diverse, in this case in terms of health status, and what is absolutely essential in terms of benefits may be a function of what category they fall into, are there other ways that we could think about varying -- other classifications we could use? In the text you say, this health status categorization is interesting conceptually but it would not be practical in terms of administering the program because of vague boundaries.

Should we be looking at other ways, age or -- recognizing that they're imperfect all of them. But I think Floyd at the last meeting suggested maybe we ought to be thinking about different benefits by age, recognizing that the general tendency is for the oldest of the beneficiaries to have the greatest needs and the greatest need for comprehensive coverage. If we've got scarce resources maybe we ought to be focusing benefits and the additional taxpayer contributions on those in the greatest need.

DR. REISCHAUER: I think that's political unsustainable and unwise, because it would be quite easy to show somebody 67-years-old who was in much worse shape and denied a set of benefits than somebody 84-years-old who was going to the gym every day. If there were a pure correlation between benefits needed and age, in effect you don't do much by segregating the benefit package by age because nobody between 65 and 70 would need the benefit that you were providing to people at an older age. So I don't think that's a way to go, for both reasons.

MR. HACKBARTH: Your points are well taken, and we can easily talk ourselves into gridlock and the status quo. It's not perfect, therefore we'll hold out for the maximum for everybody.

That has happened through Republican and Democrat administrations and various changes in congressional control. So I'm just trying to think about the problem differently.

MR. SMITH: Just quickly, Glenn. I think the issue of different packages for different cohorts, I agree with Bob I think it's politically insustainable. But also it's not clear that it's necessary. The appropriate delivery of services doesn't mean that we inappropriately deliver services to beneficiary A because beneficiary B needs them. I think that if we start down the road of different benefit packages the classification questions become enormously difficult, whereas that ought to be a clinical decision.

We don't need to sort people into either these three cohorts or anything else. I'd be very reluctant to spend much time thinking about that, and I do think the politics of it are just gruesome.

DR. BRAUN: The other problem that I see with that is I think Medicare really needs to be thought of as an insurance program rather than a means test or a cohort program or whatever. I think it's an insurance program and the idea is that you pay a little more when you're healthy and that will take care of you maybe when you're sick. I think that's really important.

I just wanted to say one other thing while I've got the floor. I think it would be a good idea to check the text and be sure that where we talk about elderly we also mention disabled, because Medicare does cover disabled as well as elderly and there are several spots where I think it needs to get mentioned.

MS. NEWPORT: I agree with Bea on the disabled piece. And the politics of trying to create different cohorts for the eligible population, I think that just would be impossible to administer or even think about in terms that are in alignment with reality.

But I did want to probe a little bit on page 14, 15, large share of the costs of Medicare managed care coverage has probably been absorbed into Medigap. I think it's important here to understand that the equivalency of the coverage will be different in Medigap even though there is, as you disenroll there's some protection in terms of allowing you, if you can afford to, get into a Med supp package.

To me, I think we should guard against making this sound like it's a perfect substitute. It is not, and I think to some extent that --

DR. THAMER: Janet, I think you're talking about the next chapter.

MS. NEWPORT: Am I?

DR. THAMER: Are you in Emerging Issues?

MS. NEWPORT: We're covering so many chapters. No, Coverage Beyond Medicare Fee-For-Service.

DR. THAMER: That's the next one, so just hold that.

MS. NEWPORT: When we get to that, I will have to say this, okay?

DR. THAMER: Hold that thought, right.

MS. NEWPORT: Okay, let me withhold. Or I can finish it and I don't have to say this later.

MR. HACKBARTH: We'll put you on the top of the list.

MS. NEWPORT: Thank you very much.

MR. FEEZOR: At some risk I'm going to come back to the chairman's efforts to try to think, because I had I think suggested maybe a tiering of benefits based not necessarily on age but on some other qualifications. It very well may be that if we can't politically differentiate -- and I think the point was made you can find the 67-year-old who in fact is every bit as ill as your 85-plus. It very well may be though that in terms of either the economic protections which Medicare tries to provide, may be different at different times. It may be looking at that construct that we may want to -- again, I'm raising a question or a perspective, whether that yields any additional thinking.

Secondly, there may be some other thresholds that may differentiate benefits that might be more needed by some of these cohorts or not. For instance, the issue of care coordination seems to be particularly acute when we get into the chronically ill, or in fact the terminally ill. It very well may be that we begin to require some threshold of participation -- not financial, but in terms of compliance and by which one can in fact get greater coverage or greater protection.

One of the things that we've worked on with some of my enrollees focus groups has been to say, given the fiscal realities we have, the choice of perhaps less benefits for everyone or some requirement that I participate, let's say in my care management or my disease management protocols in order to get additional protections, or to at least forgo maybe some additional copay requirements. Even within my constituency, which is I think very reluctant to give up on any benefits, they find that to be perhaps a prudent benefit design that makes some sense.

In other words, that if by in fact participating in my, let's say disease management or my chronic care, that in fact I either may get -- that may be a way I can channel into a fuller level of benefits or I can avoid some of the copay requirements that I might otherwise be visiting that could be available for all. So there may be some ways of, for lack of a better term, triaging into different layers of coverage that in fact may be in fact not politically -- or may not be politically objectionable and in fact may provide more effective care and even more efficient benefit design package.

DR. REISCHAUER: The Clinton administration actually suggested a number of initiatives just like that.

MR. SMITH: I think what you've suggested is interesting and worth pursuing, but has nothing to do with assigning beneficiaries to cohorts. It has to do with designing access to a benefit which is maximally efficient and it's driven by medical necessity.

DR. NELSON: My comments are not on tiering, so if you want to complete that, if there are other comments on that?

I'm going to segue into a new part of this. There's an area of overlap between benefit decisions and coverage decisions and I think it deserves a paragraph or two, particularly understanding the future implications of increasing numbers of experimental

procedures that either become a part of the benefit package by legislative fiat, like osteoporosis screening or PSA screening or whatever, when the technology transfer doesn't keep pace with what public expectations and the private sector have incorporated in their plans.

I guess I would like to see some reference to the Medicare Coverage Advisory Commission, a reference to the way currently new technology is incorporated within the existing benefits with the implications for that being a much bigger piece of -- getting more attention in the future as emerging technologies are increasing in volume and the distinction between whether it's a covered benefit under -- because it's no longer experimental and the process by which that determination, coverage determination versus benefit package determination is made.

Am I clear?

MR. HACKBARTH: I think so.

DR. THAMER: You'd like more of a discussion on currently how that's being done, how new technologies go from being experimental to being covered and how that process -- we should discuss that and what some of the caveats and limitations are of the current process.

DR. NELSON: Yes, and how that relates to our overall view of the benefit package and how we think that ought to roll out in the future. You make one reference to the fact that coverage decisions are often made at the carrier level. There are additional processes by which that's impacted. From the standpoint of the clinician that's every bit as important as what's covered in the benefit package. It's what within the current benefit package is covered and what isn't.

If concerns aren't satisfied in the traditional fashion than the next recourse is to go to Congress and get it changed.

MR. GLASS: Do you see some options coming out of that, in terms of this paper?

DR. NELSON: No, but as I read the paper that seemed an area where it was incomplete. One might think that the end of the issue comes when you decide whether it's a covered benefit. Actually there's a much -- it's much broader than that because there are things that aren't covered benefits and should be because they're still said to be experimental, by Medicare anyway, so that needs standards.

MR. GLASS: Or they're only covered in some areas.

DR. NELSON: Right.

MS. ROSENBLATT: First of all, the tone of this chapter was fine.

DR. REISCHAUER: It's not too late to revise it.

[Laughter.]

MS. ROSENBLATT: The whole subject of classifications and categorizing people in Glenn's earlier question has me thinking about the whole idea of need. It's really, when you're saying different ages might have different needs, or the classifications you used, the chronically ill, et cetera, there are different needs. It raises the whole question of, if beneficiaries have different needs than we need a different set of benefits or whatever to satisfy those different needs. You could do that

through something -- what a great name, Medicare+Choice. I mean, Choice meets different needs.

So I'm just thinking about some twist there. There was a sentence in here, we believe it would be difficult to develop criteria for assigning beneficiaries to different categories. I wrote down when I read that, consumer could choose. So I'm just wondering if we could take what Glenn said, and this whole idea of choice, and getting into what Bob said before about you could use a private program to fill in that choice idea or introduce choice in the public program.

Now adverse selection jumps into my mind and I keep saying, no, don't think about that. Let's be far-reaching. But if you could get that idea out I think that would be nice.

MS. RAPHAEL: In terms of the benefit package there's actually two groups. One group is benefits that currently exist that we think might need to be enhanced, and then there's those benefits that don't currently exist. The group that currently exists, including preventive, mental health, I think it would be useful to understand what the current expenditures are under the Medicare program. We talk about the fact that CMS is beginning to do some demos in care coordination, although I think it's more disease management, not care coordination and I think there's a difference. But even that, it would be interesting to see how much are they putting into that attempt at some innovation and what's the timetable.

I also was very interested in this chapter in the rate of growth of the under-65 population because I hadn't realized that the rate of growth there exceeded the rate of growth among the elderly. I would be interested in hearing more in this chapter about what is fueling it, because I expect there's some correlation with mental health issues and the increase in this population. But has there been some easing of restrictions for becoming qualified as disabled under Medicare, or what has transpired that has in fact led to that? I think it's important to explore that.

Then you talk about the fact that this population accounts for a disproportionate share of the mental health spending and I'd like to understand per capita or some measure of what is happening there.

DR. WAKEFIELD: I think I might have raised this at the last meeting and that's why I'm going to raise it again because I don't quite see it here. On pages 8 and 9, in particular on the section, we're talking a lot about, I think, quality of care issues. I think that's great. One thing you might want to do is take a look at the IOM's report, Crossing the Quality Chasm.

DR. THAMER: We did that. We just didn't cite it in here. But I found it and I'm sorry we didn't put it in here. You did mention it before.

DR. WAKEFIELD: Thank you. Because you've got some of those concept here. The point here is to say, that might have some ideas. Obviously it was developed to help people think through how the broader health care delivery system could be redesigned. We're talking about some redesign issues related to the Medicare program and those two activities don't necessarily have to travel

parallel and non-diverging paths. I think some of what's in that report may actually help inform our thinking and should not be lost on the Medicare program.

A couple of them you've indirectly at least picked up here, and some of that's related to care coordination, for example, in your discussion there. Although one of the problems you cite there is that, for example, medical training doesn't adequately prepare physicians to assume the role of care coordinator. I'd say in fact the issue there from my perspective is is that all health care training doesn't adequately prepare health care providers to work in teams and that's the orientation. For example, in that report it isn't who's doing the coordinating. It is very much how we maximize the capacity we've got within the system and extract more from a multidisciplinary team, as one example.

You pull in, for example, the discussion of other non-visit specific interactions between provider and patient. I think that's really good. Again, that's an IOM redesign issue that's talked about there. I would say it's not just between physicians and patients as it's described. It could be psychologists and their patients, et cetera.

Also the Quality Chasm speaks a lot to chronic care and you've got a lot of that in here too. So just wherever we might be able to marry some of those ideas, each one might give a little bit of lift to the other and I don't think that's all bad. Thanks.

MR. HACKBARTH: I want to go back to the discussion we were having a little while ago and react to David's point about the ideal to be to have access to additional benefits based on need, the clinical needs of the beneficiary. That would certainly be my ideal as well. It also would be my ideal that we expand the program in various ways because I think there are important missing pieces in the Medicare program, obviously including drugs but not limited to that.

But what I keep getting hung up on personally is our ability to afford that. Or more specifically, the ability of my children to afford that. That's what personally forces me to come back to say, even if that is our ideal, are there other ways that we can slice this? Are there other ways that we can approach it that would better target whatever additional funding is applied to the people who most need it? Age was one idea that didn't go well. Income-related benefits is another that publicly go over even less well.

But I worry if we keep saying, no, it's got to be everybody gets everything that basically we talk ourselves right into gridlock and nobody gets anything.

MS. RAPHAEL: Glenn, you could slice it by service use. You could say that if you consume a certain amount of service in some time period then you get into another tier of benefits, on the assumption that no one would want to be in the hospital five times in one year and have X episodes of SNF or home health care. That's one way that you could do it, because I think going to income or age is not workable.

DR. REISCHAUER: How does that save you any money though?

MS. RAPHAEL: It doesn't.

DR. REISCHAUER: Because nobody in the other tiers would have used it anyway.

MR. SMITH: No, but Carol states a way -- we could change copays depending upon consumption. That would address at least both pieces of the problem. But the notion that we're going to put Bob in a tier and he will have access to a benefit package that's different than mine based on income would be the most disturbing flashpoint. But also on this --

DR. REISCHAUER: Just call it a catastrophic cap.

MR. SMITH: A catastrophic cap shouldn't be off the table, some sort of consumption-driven changes in copays shouldn't be off the table. But there's no reason why a comprehensive benefit package means somehow we're all going to promiscuously consume things that we don't need. That has much more to do with the copayment design, Glenn, than with the benefit package.

MR. HACKBARTH: Just for the record, you're misunderstanding my point. It isn't about promiscuous, inappropriate consumption. It's about a real legitimate need but how do we pay for it, how do our kids pay for it?

One of the nice features of this report is that we don't need to resolve this question. I'm not asking that we resolve the question. I would like the text to address this as an issue, an issue on which reasonable people can disagree. But I think it is at the nub of why we've had so much difficulty, over years of administrations of all varieties, in making progress on this issue. I think to pretend it isn't the question, it's just not appropriate.

DR. REISCHAUER: But we're paying for it already. We're paying for it through supplementary premiums. We're paying for it through out-of-pocket spending. It's just that the distribution of how we would pay for it would change.

MR. HACKBARTH: But that's a critical difference.

DR. REISCHAUER: And that's the political issue.

MR. HACKBARTH: Right. But the distribution of the burden, who's paying for it, is extremely important. In some ways we say to our kids, you've got to pay it all. In other ways, people are, participants in the system pay at least part of it. Therein is a very big difference.

MR. SMITH: Glenn, I don't disagree. The questions of how do we pay for it are important ones. But I think we are in very dangerous territory if before we've thought about what is in the appropriate benefit package and how do we allocate that against medical necessity rather than some ability to pay-driven metric, and start saying, no, we can't go there because it might cost something, there's a critical question, you're right. How do we pay for what we think is appropriate? But let's not negotiate with ourselves about the second question before we answer the first.

DR. ROSS: I'm sitting here trying to figure out how on earth these guys are going to write this up.

MR. HACKBARTH: Carefully.

DR. ROSS: Carefully, yes, with no tone. But as I listen to Carol talk about condition-driven benefits, and that was kind of

your point, David, that you have a uniform benefit package but only certain people consume it. It's available to all. I could think of that with things the way we do with care in skilled nursing facilities, minimum three-day hospital stay. If you're really sick and you've been in the hospital for 10 days, now we'll give you some care coordination or something like that. You can at least think of some instances there.

Operationally though I have a harder time thinking about how you'd take a small bite of the prescription drug apple on anything but income grounds or something like that.

We could take a crack at this. I suspect in the time available we would have a hard time framing all of this in a way that satisfies all of you.

MR. GLASS: Murray, there is one example in the Medicare package where we do something that which is hospice. There you have to meet a certain diagnosis to be in it, and then you have to give something up to get into it. You have to give up curative.

MS. RAPHAEL: You have to give up traditional Medicare fee-for-service.

MR. GLASS: Right, so conceivably you could say for some benefits you have to give up some choice of provider or something like and that would be possible.

DR. ROSS: We call that Medicare+Choice. To give up your choice of provider you go into another program.

DR. THAMER: There are precedents in other health care systems where you can, having a certain number or type or severity of medical conditions, or a certain number of functional limitations will get you into a different set of packages. There are examples like that that are operational today but they're difficult to do.

MR. HACKBARTH: We're going to have to bring this to a conclusion.

DR. STOWERS: Mine is leaving this a little bit but it kind of gets back to maybe what even ought to be in that introductory chapter is some sense of order of how Congress or we would approach this, is a matter of trying to figure out what benefit package and all of that, but that's dependent upon what we can afford or not afford, whether we're going to distribute it or whatever. But we don't know unless we do the reorganization first with the Medigap and all the other things of what's going to be saved out of that. We don't know what quantity one way or the other.

So I think we ought to approach Congress more from we ought to be putting our efforts into creating these efficiencies that we're talking about, and then from that know a little bit more what this benefit package can be. But we seem to be just charging into all of it at the same time and not really giving direction as to how it ought to be approached. I think maybe we could do that if we all agree that the reorganization and that kind of savings should be up front to see what we're going to have to spend afterwards.

DR. LOOP: I thought each of these chapters was interesting and fairly well written, but together they're sort of redundant.

I think you could compress a lot of this. This one was a little wandering, so let me wander around a little bit more.

Somewhere in these chapters you have to say, and you actually said this in the appendix of the first one, that Medicare was designed as an acute care program and it has evolved into, there's now more disability and now we have an aging population. The discussion here has pointed out that there's some politically undoable things like indexing to income and perhaps indexing to age. You can't tier it based on age even though the oldest-old are definitely going to consume more resources.

I think maybe as long as we're talking about politically undoable things we should look at maybe we should expunge the word catastrophic care. We haven't quite gotten to that yet. And look at instead, change the threshold for expensive medical care, expensive medical necessities. Because the only way that we can remodel Medicare -- because what we're really talking about is expanding Medicare benefits. It's not longer just acute care. We're going into pharmaceuticals, long term care, and what we formerly called catastrophic care.

To do this, the only way we can do it and keep the cost under control the government is cost sharing on the part of the individual. I think it has to be stated up front that that's what we're really talking about. If we're going to expand Medicare benefits and we're not going to have the government do it all, then it has to be on the back of the beneficiary. Now I haven't said that very well but I think at the beginning of these chapters, or in the middle someplace, you have to say that, which I don't read it that way.

MR. HACKBARTH: This is thought provoking, which is the whole reason for doing the report. There will be lots of interesting issues raised. We look forward eagerly to the next draft.

We need to move on though right now to our next section, coverage beyond the fee-for-service benefit package. Go ahead, Chantal, whenever you're ready.

* DR. WORZALA: Good afternoon. Today I will focus mostly on the results regarding the association between supplemental coverage and access to care and use of necessary services. Of course I do welcome your comments on the whole chapter including the tone.

This slide, which you saw last month, summarizes the eligibility restrictions, benefits, and enrollment for each source of additional coverage. That is, employer-sponsored insurance, Medigap, Medicare managed care, and Medicaid. Not on this chart are other sources of coverage such as the VA, military, and state programs. Those programs together cover about 2 percent of beneficiaries and about 9 percent had no additional coverage in 1999. Our best guess for 2002 is that has increased to about 11 percent without some sort of additional coverage.

I want to draw your attention to a couple of broad points rather than going through each cell. First, the scope of additional coverage does vary by the source. In general, full

Medicaid coverage is the most comprehensive at filling both Medicare's cost sharing requirements and at covering non-Medicare benefits like prescription drugs, preventive services, and even long term care. Employer-sponsored insurance tends to be the second most comprehensive.

Medigap, on the other hand, focuses primarily on cost sharing with the exception of those plans that cover preventive services or prescription drugs. Medicare managed care plans were fairly comprehensive in the late 1990s and offered additional benefits with low cost sharing. But as we have discussed previously, they are becoming less generous over time.

The second major point is that access to these sources of additional coverage is not universal. Each source has eligibility restrictions as listed. This becomes important when we look at the relationship between supplemental coverage and access to care.

People without additional coverage report less access to care. The chart you see here gives the results for three self-reported measures that are included in the Medicare current beneficiary survey access to care file. These are 1999 results.

As you can see, compared to those with employer-sponsored insurance or Medigap, beneficiaries with only Medicare fee-for-service benefits were nearly six times as likely to report having delayed care due to cost, about four times as likely to lack a usual source of care, and about four times more likely to report having trouble getting care. While these numbers do raise concerns about access to care for those without an additional source of coverage it's important to recognize that there may be other factors that are correlated with both these access measures and insurance status and these things may confound our results.

For example, you can see on this chart that beneficiaries with the most generous form of additional coverage, that is Medicaid, also report less access to care than those with employer-sponsored insurance or Medigap. This population is most similar to the Medicare-only population in both health status and income. Other factors such as education and culture, and knowledge of the health care system may impact care-seeking behavior and other determinants of access to care.

I'm not trying to suggest that there's no effect from having supplemental coverage. It seems clear that there is. However, in future work I think multivariate analysis might help us to better understand how much of these differences are due to lack of additional coverage rather than other factors.

So assess the relationship between supplemental insurance and use of necessary care we analyzed the access to care for the elderly project indicators, or ACE-PRO indicators by supplemental insurance status. These indicators were developed by the RAND Corporation and funded at least partially by PPRC. They were developed by clinicians and health services researchers to be evidence-based and clinically valid. They consider both preventive services and 14 medical or surgical conditions that are common among the elderly, such as hypertension, diabetes, hip fracture, and depression.

A total of 36 indicators were developed under the project.

We analyzed 22 of those indicators that were applicable to at least 20 individuals with only Medicare fee-for-service coverage in our data set. Chris Hogan, who is in the audience back there, performed the analysis for us.

The indicators we looked at include three preventive services, such as a yearly exam for all beneficiaries or a mammogram every two years for female beneficiaries under the age of 75. We also looked at 13 necessary services for specific conditions and six avoidable outcomes. These indicators were designed to measure necessary care which was defined as follows: the benefits of the care outweigh the risks; the benefits to the patient are likely and substantial; and physicians have judged that not recommending this care would be improper. In that respect then, these indicators represent a floor of clinically appropriate care and they do not measure any sort of ideal care.

The data for this analysis came from the 1996 through 1999 MCBS cost and use files which include the claims. The analysis was conducted only on those over age 64 and Medicare managed care enrollees were unfortunately dropped out of the analysis because their claims data were incomplete.

I should just note, for all of this chapter we define supplemental insurance status as that in which -- what the beneficiary had for at least six months out of the year. So that's how we're defining, for example, employer-sponsored insurance, they had it for at least six months, or for only Medicare fee-for-service that was true for at least six months in the year.

Overall we see that the analysis found that people without supplemental insurance use less necessary care. Of the 20 indicators we looked at, 10 showed less use of necessary care by those without supplemental insurance, including all of the preventive services indicators. Only one showed greater use of necessary care by those without supplemental insurance, and 11 showed no statistically significant difference. Of those 11, six were avoidable adverse outcome indicators, and it's not too surprising that these were statistically insignificant due to the rarity of avoidable outcomes.

Getting into some of the specific indicators here are the results for the three preventive services. You can see that the differences between the two groups are large. All of these differences are statistically significant. If we single out mammography every two years for female beneficiaries under the age of 75 we see that while 62 percent of those with supplemental coverage do get these recommended routine mammograms, only 27 percent of those with no supplemental coverage do. That's a 35 percentage point difference, which is clearly quite large.

Similarly, for a visit a year, the difference is 19 percentage points, and for assessment of visual impairment every two years the difference is 25 percentage points.

On the next slide, to give you a flavor of the results pertaining to use of necessary care for specific conditions, here are the results for three of the indicators. The full results are in your briefing papers. That's Table 2B-3. The first indicator that I've highlighted for you here is a preventive

measure which is an eye exam every year for patients with diabetes. Here we can see that those without supplemental coverage are substantially less likely to have this exam done than those who have it; it's a 17 percentage point difference.

The second here is a monitoring indicator and that's a visit every six months for patients with congestive heart failure. The gap between those with and without supplemental coverage is smaller here but still seven percentage points. I think the good news on this indicator is that clearly all of these people are, for the most part, being monitored.

The third is a surgical procedure which is repair of a hip fracture during hospitalization. Here too we see a gap of 10 percentage points between those with and without supplemental coverage.

Clearly these results suggest that the cost sharing and gaps in the fee-for-service benefit package may dissuade some beneficiaries without supplemental coverage from getting needed care.

Those were the results regarding the association between supplemental insurance and access to care and use of necessary services. They suggest that this kind of coverage affords beneficiaries with a level of financial protection that promotes access to care. However, that access to care does come at a price and there are aspects of the patchwork of additional coverage that make it less than optimal and suggest that there might be more efficient ways to provide the same benefits and access to care.

First, the system of multiple sources of additional coverage confuses beneficiaries and providers. I want to be clear that we're talking here about the system and the fact that there are all these different sources: employer-sponsored, Medicaid, Medigap. I'm not singling out any one of those sources.

Second, having multiple sources -- and here again I'm talking about all of them -- raises administrative costs. This is especially true given that some beneficiaries, and that's about 12 percent in 1998, hold more than one supplemental product.

Third, a body of research has demonstrated that generous coverage of cost sharing leads to increased use of services, resulting in higher premiums for beneficiaries and higher costs for the Medicare program. The size of this effect varies across studies. Whether or not the increased usage is completely unnecessary is not known, but I think the direction of the effect is fairly clear.

Finally, a substantial sum of all resources spent on beneficiary health care, excluding long term care, does flow through private and governmental sources of additional coverage. We estimate that to be about 20 and 25 percent of all resources. As Anne and Ariel will discuss, those resources might be better allocated to improve beneficiaries' financial protection and their access to care.

I'll stop there.

MS. NEWPORT: I'll repeat, or try to, what I was trying to say earlier. I was just trying to get this done. Anyway, I

appreciate your patience.

Again, I think that I was concerned that, as it regards to managed care exits out of M+C, that going into Med supp, and obviously there will be increasing participation in those areas, but I don't think that we should leave people with the potential impression that that's a perfect substitute because the scope of the coverage may be very different even though they have protection in terms of elimination of preexisting conditions and getting into Medigap coverage in those areas.

Then on your slide, I think that one of the things about generous coverage of cost sharing leads to higher cost for the Medicare program, I think that I would like to see that more carefully constructed to say that the removal of financial barriers to accessing care could improve quality, although it is acknowledged that people are getting the necessary. I think that I would hope that as you go forward and edit this that that's clear.

These are economic barriers. If you don't have supp coverage or the deductibles and copays are so high that it does chill, in a very bad way, people's ability to go and seek care when they need. Since your data shows that, let's change that around.

MS. ROSENBLATT: In general the tone here was okay, too. The issue I had on here was on the -- there's a whole page on admin costs, particularly for the supplemental coverages. I already made the comment that there's a reference in here on page 13 to admin costs for Medigap plans average 20 percent. There is a pretty wide range, so if you've got -- I don't know what the DePaul study is but if it's got a range that would be helpful.

Comparing that 20 percent to admin costs of 11 percent for M+C is strange because it's 11 percent of a much bigger number. The Medicare+Choice, I think you're getting the 11 percent of the total to cost as opposed to just the cost of the supplement. Then I've already talked before about the 2 percent for Medicare. So if you could just put some language in that you're not really comparing apples to apples, because I think the reader is left with 20, 11, two, without realizing that you've got some apples and oranges there.

The other thing is, in terms of the difficulty of the administrative stuff, I don't know what the generic term for this is and maybe Glenn or Lu knows, but some of the Blue plans do something called crossover. I know it as crossover, where the Blue plan is both the intermediary and also has Med supp. The individual is only submitting a claim once. There's no language in here about that.

DR. REISCHAUER: Chantal, for these differences, I presume that these are just raw differences between those with some supp and those with none. I think we know that of individuals with identical insurance policies, those with lower educational levels, lower income, living in rural areas, non-English speakers use fewer medical services than those in the other category. We know that factors like that are positively correlated with lack of supplemental insurance. So this is, in a sense, an overestimate of the difference that is attributable to lack of

supplemental insurance and we should just make some reference somewhere to that.

MR. HACKBARTH: Any others?

MR. FEEZOR: Just a question. When we refer to those with supplemental coverage as using more services generally, is that over their entire lifetime or is that simply measured as year to year?

DR. WORZALA: Most of the studies are annual. I'm not aware of any lifetime studies. That would be interesting.

MR. FEEZOR: It would be. Do you access the services you need earlier and pay more so you may show up, and yet at the end may -- just curious if there is such. Like to see that at some point.

MR. HACKBARTH: Thank you.